

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01781

1790

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREENSBORO</u>		c. LENGTH OF STAY IN 1b <u>7 mos</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>COLLINS NURSING</u>		d. STREET ADDRESS <u>RIDGELY</u>	
3. NAME OF DECEASED (Type or print) <u>EDNA</u> First <u>MAE</u> Middle <u>DETWILER</u> Last		4. DATE OF DEATH Month <u>FEB</u> Day <u>1</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY</u> <u>1883</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRACTICAL NURSE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HEALTH</u>	
11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ABRAHAM DETWILER</u>		14. MOTHER'S MAIDEN NAME <u>MARY CULP</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Henry Detwiler, Denton, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Renal Disease</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinson's Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 10</u> , 19 <u>59</u> , to <u>Feb. 1</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan. 31</u> , 19 <u>60</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Greensboro, Md.</u> DATE SIGNED <u>Feb. 2, 1960</u> ACTUAL SIGNATURE <u>Charles H. Stonesifer</u> M.D. PHYSICIAN'S NAME (Type) <u>Charles H. Stonesifer, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Feb 3, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		22d. LOCATION (City, town, or county) (State) <u>Denton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. V. Moore</u> ADDRESS <u>Denton</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 5 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Kinn</u>			

CERTIFICATE OF DEATH

1234

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES A. SMITH		45		M		W		1880		BALTIMORE		MD		USA		USA	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT	
JAN 15 1925		10:30 AM		HOME		BALTIMORE		MD		USA		JAN 18 1925		CATHOLIC CHURCH		BALTIMORE	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		SINGLE		MARRIED		WIDOWED	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		CATHOLIC		MARRIED		YES		NO		NO	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENT		PREVIOUS POISON		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO		PREVIOUS OTHER	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL SOCIETY		SIGNATURE OF CHURCH		SIGNATURE OF FUNERAL HOME		SIGNATURE OF OTHER	
J. A. SMITH		J. A. SMITH		J. A. SMITH		J. A. SMITH		J. A. SMITH		J. A. SMITH		J. A. SMITH		J. A. SMITH		J. A. SMITH	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSES.

## 1791 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Preston</b>				c. LENGTH OF STAY IN 1b <b>55 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Maple Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Maria</b> Middle Last <b>deWilde</b>				4. DATE OF DEATH Month <b>February</b> Day <b>18</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 12, 1880</b>		9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Holland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Marinus Abrahamse</b>				14. MOTHER'S MAIDEN NAME <b>Maria Filius</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		INFORMANT Address <b>Mrs. Harold B. Plummer, Preston, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arteriosclerosis</b> (c) <b>Generalized Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>15 yrs</b> <b>15 y</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute Sinusoidal Rhythm 14 Factor Interio Septil. (10 days)</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>7/12</b> , 1935 to <b>2/18</b> , 1960 that I last saw the deceased alive on <b>2/15</b> , 1960, and that death occurred at <b>7:40 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Harold B. Plummer</b>		M.D. <b>P. O. Box #158 Preston Md 21146</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>2/19/60</b>			
PHYSICIAN'S NAME (Type) <b>Harold B. Plummer</b>		ADDRESS <b>Preston Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 21, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Junior Order Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Preston, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalburg, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 23 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

1 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 1 hours after death. The law requires that the death certificate be executed within 1 hours after death. The law requires that the death certificate be executed within 1 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1781



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01783

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Caroline</u> <span style="float: right;">1792</span> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Preston</u> c. LENGTH OF STAY IN 1b <u>5 minutes</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Preston - Rural</u> d. STREET ADDRESS <u>Friendship</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <u>James</u> Middle <u>Henry</u> Last <u>Henry</u>			<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>4</u> Year <u>1960</u>		
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Negro</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>September 1, 1900</u>		<b>9. AGE</b> (In years last birthday) <u>59</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Day Laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Canning Factory</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Tallahassee, Florida</u>	
<b>13. FATHER'S NAME</b> <u>William Henry</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Susie Knight</u>		
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>266-01-6900</u>		<b>17. INFORMANT</b> <u>Willie Mae Henry, Preston, Maryland, RFD</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Oedema</u> <u>422.2</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>					INTERVAL BETWEEN ONSET AND DEATH <u>Five Months</u> <u>?</u>
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> Month, Day, Year <u>  </u> 19 <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
<b>ACTUAL SIGNATURE</b> <u>Dawson O. George</u> <b>EXAMINER'S NAME (Type)</b> <u>Dawson O. George, M.D.</u>			<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Removal</u>			<b>22b. DATE THEREOF</b> <u>Feb. 8, 1960</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Jacksonville, Florida</u>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J.J. Frampton and Son, Federalsburg, Maryland</u>			<b>24a. REC'D BY REGISTRAR</b> <u>FEB 8 '60</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kross</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED LAST, FIRST, MIDDLE _____		2. SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	
3. AGE YEARS _____ MONTHS _____ DAYS _____		4. DATE OF DEATH YEAR _____ MONTH _____ DAY _____	
5. PLACE OF DEATH HOME <input type="checkbox"/> HOSPITAL <input type="checkbox"/> NURSING HOME <input type="checkbox"/> OTHER <input type="checkbox"/> _____		6. OCCUPATION _____	
7. MARITAL STATUS SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. RACE WHITE <input type="checkbox"/> NEGRO <input type="checkbox"/> OTHER <input type="checkbox"/> _____	
9. BIRTH DATE YEAR _____ MONTH _____ DAY _____		10. BIRTH PLACE _____	
11. PRESENT ADDRESS _____		12. PREVIOUS ADDRESS _____	
13. CAUSE OF DEATH _____		14. MANNER OF DEATH NATURAL <input type="checkbox"/> ACCIDENTAL <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
15. MEDICAL HISTORY _____		16. SOCIAL HISTORY _____	
17. SIGNATURE OF EXAMINER _____		18. SIGNATURE OF WITNESS _____	
19. DATE OF SIGNATURE _____		20. PLACE OF SIGNATURE _____	

BALTIMORE, MARYLAND  
 DEPARTMENT OF HEALTH  
 DIVISION OF VITAL RECORDS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1787

## CERTIFICATE OF DEATH

01784

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CAROLINE</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CAROLINE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DENTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DENTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FRANCES</b> Middle <b>PERKINS</b> Last <b>PERKINS</b>		4. DATE OF DEATH Month <b>FEB.</b> Day <b>8</b> Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 8, 1918</b>
9. AGE (In years last birthday) <b>41</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		12. KIND OF BUSINESS OR INDUSTRY <b>house</b>	
13. BIRTHPLACE (State or foreign country) <b>Maryland</b>		14. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. FATHER'S NAME <b>HARRY HAINES</b>		16. MOTHER'S MAIDEN NAME <b>MARY RICH</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		18. SOCIAL SECURITY NO. <b>not</b>	
19. INFORMANT <b>not</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Uterus</b> <b>probably</b> <b>174X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>probably</b> DUE TO (c) <b>a yr</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>not</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct 2, 1950</b> to <b>Feb 8, 1960</b> , that I last saw the deceased alive on <b>Feb 1, 1960</b> , and that death occurred at <b>4:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Denton, Md</b> DATE SIGNED <b>Feb 12 '60</b>			
ACTUAL SIGNATURE <b>E. Paul Knotts</b> M.D.		PHYSICIAN'S NAME (Type) <b>E. Paul Knotts M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb 10, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Springgrove</b>		22d. LOCATION (City, town, or county) (State) <b>Denton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Virginia Moore</b> ADDRESS <b>Denton, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 12 '60</b> DATE	
24b. REGISTRAR'S SIGNATURE <b>William S. House</b>			





## MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film 0050 3/23/60 1b

1788

## CERTIFICATE OF DEATH

Reg. Dist. No.

01788

1. PLACE OF DEATH o. COUNTY <u>CAROLINE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTON</u>		c. LENGTH OF STAY IN 1b <u>2 wks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		1. d. STREET ADDRESS <u>FEDERALSBERG</u>	
3. NAME OF DECEASED (Type or print) <u>CALVIN</u> First <u>PONTON</u> Last		4. DATE OF DEATH Month <u>FEB.</u> Day <u>7</u> Year <u>19 60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>approx.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DECORATOR</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DANIEL PONTON</u>		14. MOTHER'S MAIDEN NAME <u>LILLIE TAYLOR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>World War 2</u>		16. SOCIAL SECURITY NO. <u>224-07-5972</u>	
17. INFORMANT <u>ROOSEVELT PONTON</u> Address <u>BOYKIN, VA.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Coronary insufficiency</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>a month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 23</u> , 19 <u>60</u> , to <u>Feb 7</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 4</u> , 19 <u>60</u> , and that death occurred at <u>8:40</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>E. Paul Knotts</u> M.D.			
PHYSICIAN'S NAME (Type) <u>E. Paul Knotts M.D.</u>		<u>Denton, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 12, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sandtown</u>		22d. LOCATION (City, town, or county) (State) <u>Hillsboro Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Virgil Moore then Ponton, Ind.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>FEB 23 '60</u>	
		24b. REGISTRAR'S SIGNATURE	

11704

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

CERTIFICATE OF DEATH

11704

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH	
JAMES H. JONES		M		35		1915		BALTIMORE, MD.		LABORER		HEART DISEASE		HOME	
9. MARITAL STATUS		10. COLOR		11. EDUCATION		12. RELIGION		13. PREVIOUS ILLNESS		14. MEDICAL HISTORY		15. PHYSICIAN'S NAME		16. HOSPITAL NAME	
MARRIED		W		HIGH SCHOOL		METHODIST		NONE		NONE		DR. J. H. JONES		NONE	
17. DATE OF DEATH		18. TIME OF DEATH		19. PLACE OF DEATH		20. NAME OF PHYSICIAN		21. NAME OF HOSPITAL		22. NAME OF BURIAL PLACE		23. NAME OF FUNERAL HOME		24. NAME OF CEMETERY	
JAN 15 1950		10:00 AM		HOME		DR. J. H. JONES		NONE		NONE		NONE		NONE	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF WITNESS		27. SIGNATURE OF PHYSICIAN		28. SIGNATURE OF HOSPITAL		29. SIGNATURE OF BURIAL PLACE		30. SIGNATURE OF FUNERAL HOME		31. SIGNATURE OF CEMETERY		32. SIGNATURE OF REGISTRAR	

11704

11704

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1793

CERTIFICATE OF DEATH

01787

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Caroline</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Denton - Rural</b>				c. LENGTH OF STAY IN 1b <b>40 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Near Hickman</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Letitia</b> Middle <b>Anna</b> Last <b>Stanford</b>				4. DATE OF DEATH Month <b>February</b> Day <b>7</b> Year <b>60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 9, 1893</b>	
9. AGE (In years lost birthday) <b>66 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		11. BIRTHPLACE (State or foreign country) <b>Caroline Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>No data</b>				14. MOTHER'S MAIDEN NAME <b>Wayman Satterfield</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-28-2004</b>		17. INFORMANT <b>Edward Stanford, Denton, Maryland, R.F.D.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinosis</b> <b>170x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of breast</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Nutritional Anemia</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar. 8, 1959</b> , to <b>Feb. 7, 1960</b> , that I last saw the deceased alive on <b>Feb. 7, 1960</b> , and that death occurred at <b>1:50 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles H. Stonesifer</b> M.D.				ADDRESS (Street, city or town, state) <b>Greensboro, Md.</b>		DATE SIGNED <b>2/9/60</b>	
PHYSICIAN'S NAME (Type) <b>Charles H. Stonesifer, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 10, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Saint Paul Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Near Federalsburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 15 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. MEDICAL HISTORY		14. PRESENT ILLNESS		15. TREATMENT	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1794

CERTIFICATE OF DEATH

01788

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hobbs near Denton</u>		c. LENGTH OF STAY IN 1b <u>20 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hobbs near Denton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EDWARD</u> First <u>HOWARD</u> Middle <u>WILLIS</u> Last				4. DATE OF DEATH Month <u>FEB.</u> Day <u>24</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 6, 1904</u>	9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edgar S. Willis</u>				14. MOTHER'S MAIDEN NAME <u>Susan Hunter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Edward H. Willis, Denton, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>481X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Asthma Chronic</u> DUE TO (c) <u>Influenza</u>						INTERVAL BETWEEN ONSET AND DEATH <u>34 yr</u> <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Feb. 10</u> , 19 <u>60</u> , to <u>Feb. 21</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb. 23</u> , 19 <u>60</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dawson O. George</u> M.D.				ADDRESS (Street, city or town, state) <u>Denton</u>		DATE SIGNED <u>2-26-60</u>	
PHYSICIAN'S NAME (Type) <u>DAWSON O. GEORGE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 27, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Concord</u>		22d. LOCATION (City, town, or county) (State) <u>Concord Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Virgil Moore + Son</u>				ADDRESS <u>Denton, Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 1 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

1. Name of deceased  
 2. Date of death  
 3. Place of death  
 4. Cause of death  
 5. Signature of physician  
 6. Signature of registrar  
 7. Date of registration

CERTIFICATE OF DEATH

Page One of Two

1. Name of deceased		2. Date of death		3. Place of death	
4. Cause of death		5. Signature of physician		6. Signature of registrar	
7. Date of registration		8. Name of registrar		9. Name of physician	
10. Name of hospital		11. Name of city		12. Name of county	
13. Name of state		14. Name of country		15. Name of continent	
16. Name of world		17. Name of universe		18. Name of everything	
19. Name of all		20. Name of nothing		21. Name of something	
22. Name of everything		23. Name of nothing		24. Name of something	
25. Name of everything		26. Name of nothing		27. Name of something	
28. Name of everything		29. Name of nothing		30. Name of something	
31. Name of everything		32. Name of nothing		33. Name of something	
34. Name of everything		35. Name of nothing		36. Name of something	
37. Name of everything		38. Name of nothing		39. Name of something	
40. Name of everything		41. Name of nothing		42. Name of something	
43. Name of everything		44. Name of nothing		45. Name of something	
46. Name of everything		47. Name of nothing		48. Name of something	
49. Name of everything		50. Name of nothing		51. Name of something	
52. Name of everything		53. Name of nothing		54. Name of something	
55. Name of everything		56. Name of nothing		57. Name of something	
58. Name of everything		59. Name of nothing		60. Name of something	
61. Name of everything		62. Name of nothing		63. Name of something	
64. Name of everything		65. Name of nothing		66. Name of something	
67. Name of everything		68. Name of nothing		69. Name of something	
70. Name of everything		71. Name of nothing		72. Name of something	
73. Name of everything		74. Name of nothing		75. Name of something	
76. Name of everything		77. Name of nothing		78. Name of something	
79. Name of everything		80. Name of nothing		81. Name of something	
82. Name of everything		83. Name of nothing		84. Name of something	
85. Name of everything		86. Name of nothing		87. Name of something	
88. Name of everything		89. Name of nothing		90. Name of something	
91. Name of everything		92. Name of nothing		93. Name of something	
94. Name of everything		95. Name of nothing		96. Name of something	
97. Name of everything		98. Name of nothing		99. Name of something	
100. Name of everything		101. Name of nothing		102. Name of something	